		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0021238

Facility Name: P.A. Peterson Center for Health

Address: 1311 Parkview Ave. (Number) Rockford, Illinois (City) 61107 (Zip Code)

County: Winnebago

Telephone Number: (815) 399 - 8832 **Fax #** (815) 399 - 8342

IDPA ID Number: 36-2584799 - 004

Date of Initial License for Current Owners: 1941

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code 501 (C) (3)		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Sonia Channa **Telephone Number:** (847) 390 - 1411

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2003 to 06/30/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Frederick Aigner
(Title) President

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 174 Date of change 08/15/02

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	122	Skilled (SNF)	122	44,652	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	52	Sheltered Care (SC)	52	19,032	5
6		ICF/DD 16 or Less			6
7	174	TOTALS	174	63,684	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			7,906	7,906	8
9	SNF/PED					9
10	ICF	9,571	19,583		29,154	10
11	ICF/DD					11
12	SC		5,807		5,807	12
13	DD 16 OR LESS					13
14	TOTALS	9,571	25,390	7,906	42,867	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.31%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N / A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [N / A]

I. On what date did you start providing long term care at this location?
Date started 1941

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 28 and days of care provided 7,906

Medicare Intermediary Adminastar

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/2004 Fiscal Year: 06/30/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	379,995	25,359	24,842	430,196		430,196		430,196			1
2	Food Purchase		268,687		268,687		268,687	(7,347)	261,340			2
3	Housekeeping	131,338	31,530	26	162,894		162,894		162,894			3
4	Laundry		3,933	139,276	143,209		143,209		143,209			4
5	Heat and Other Utilities			209,714	209,714	3,633	213,347	(12,864)	200,483			5
6	Maintenance	121,534	35,762	145,985	303,281	13,607	316,888		316,888			6
7	Other (specify):* Rubish/Medical Removal			14,019	14,019	1,310	15,329		15,329			7
8	**TOTAL General Services**	632,867	365,271	533,862	1,532,000	18,550	1,550,550	(20,211)	1,530,339			8
	B. Health Care and Programs											
9	Medical Director			6,503	6,503		6,503		6,503			9
10	Nursing and Medical Records	2,920,169	381,323	79,351	3,380,843		3,380,843		3,380,843			10
10a	Therapy			1,040,133	1,040,133		1,040,133		1,040,133			10a
11	Activities	56,516	5,018		61,534		61,534		61,534			11
12	Social Services	104,314		413	104,727		104,727		104,727			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,080,999	386,341	1,126,400	4,593,740		4,593,740		4,593,740			16
	C. General Administration											
17	Administrative	42,655			42,655	358,831	401,486		401,486			17
18	Directors Fees											18
19	Professional Services			902,013	902,013	(638,270)	263,743	(919)	262,824			19
20	Dues, Fees, Subscriptions & Promotions			28,073	28,073	4,657	32,730		32,730			20
21	Clerical & General Office Expenses	113,654	29,473	52,508	195,635	33,196	228,831		228,831			21
22	Employee Benefits & Payroll Taxes			947,851	947,851	89,148	1,036,999		1,036,999			22
23	Inservice Training & Education					5,322	5,322		5,322			23
24	Travel and Seminar			22,100	22,100		22,100		22,100			24
25	Other Admin. Staff Transportation					7,938	7,938		7,938			25
26	Insurance-Prop.Liab.Malpractice			270,986	270,986	18,584	289,570		289,570			26
27	Other (specify):* Fundraising					49	49	(49)				27
28	**TOTAL General Administration**	156,309	29,473	2,223,531	2,409,313	(120,545)	2,288,768	(968)	2,287,800			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,870,175	781,085	3,883,793	8,535,053	(101,995)	8,433,058	(21,179)	8,411,879			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number P.A. Peterson Center for Health #0021238 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			401,821	401,821	52,650	454,471	(22,817)	431,654			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			231,651	231,651	10,817	242,468	(5)	242,463			32
33	Real Estate Taxes			130,069	130,069	226	130,295		130,295			33
34	Rent-Facility & Grounds					36,060	36,060		36,060			34
35	Rent-Equipment & Vehicles			36,992	36,992	2,242	39,234		39,234			35
36	Other (specify):*											36
37	**TOTAL Ownership**			800,533	800,533	101,995	902,528	(22,822)	879,706			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,320	61,320		61,320		61,320			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			61,320	61,320		61,320		61,320			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,870,175	781,085	4,745,646	9,396,906		9,396,906	(44,001)	9,352,905			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(7,347)	2		4
5	Telephone, TV & Radio in Resident Rooms	(12,864)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(19,717)	30		9
10	Interest and Other Investment Income	(5)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(4,068)	9,27,30		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (44,001)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (44,001)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

P.A. Peterson Center for Health

ID# 0021238

Report Period Beginning: 07/01/2003

Ending: 06/30/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Adjust in Advertising & Promotions- Mgmt	$ 117	27	1
2	Adjust out Advertising & Promotions-Serv Network	(166)	27	2
3	Adjust Allowable Mgmt & HR allocation	(919)	19	3
4	Adjust Allowable Service Network Allocation	0	19	4
5	Adjust Out Management auto depreciation	(351)	30	5
6	Programs Auto (over one limit)	(1,541)	30	6
7	1995 CORF Adjustment IDPA	(1,208)	30	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(4,068)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 **Report Period Beginning:** 07/01/2003 **Ending:** 06/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(7,347)	0	0	0	0	0	0	0	0	0	0	(7,347)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(12,864)	0	0	0	0	0	0	0	0	0	0	(12,864)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(20,211)	0	0	0	0	0	0	0	0	0	0	(20,211)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(919)	0	0	0	0	0	0	0	0	0	0	(919)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(49)	0	0	0	0	0	0	0	0	0	0	(49)	27
28	**TOTAL General Administration**	(968)	0	0	0	0	0	0	0	0	0	0	(968)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(21,179)	0	0	0	0	0	0	0	0	0	0	(21,179)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 **Report Period Beginning:** 07/01/2003 **Ending:** 06/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(22,817)	0	0	0	0	0	0	0	0	0	0	(22,817)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5)	0	0	0	0	0	0	0	0	0	0	(5)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(22,822)	0	0	0	0	0	0	0	0	0	0	(22,822)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(44,001)	0	0	0	0	0	0	0	0	0	0	(44,001)	45

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A	N/A	N/A	N/A	Vesper Mgmt Corp	Des Plaines Illinois	Mgmt co.
				LSSI	Des Plaines Illinois	Corp. Office

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		N/A	$	N/A		$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lutheran Social Services of Illinois
Street Address: 1001 E. Touhy Ave. Ste 50
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (847) 635-4600
Fax Number: (847) 635-6764

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	Non Capital Direct Costs	29,215,047	265	$ 1,898,520	$ 1,898,520	3,087,165	$ 200,617	1
2	22	Empl Benefits & Taxes		29,215,047	265	358,198		3,087,165	37,851	2
3	19	Prof Fees & Contract		29,215,047	265	1,831,337		3,087,165	193,518	3
4	21	Supplies, Telephone		29,215,047	265	196,737		3,087,165	20,789	4
5		Postage, Out. Printing		29,215,047	265	0		3,087,165	0	5
6	34	Rental of Space		29,215,047	265	338,143		3,087,165	35,732	6
7	5	Utilities		29,215,047	265	34,385		3,087,165	3,633	7
8	6	Bldg Repairs & Maintenance		29,215,047	265	920		3,087,165	97	8
9	32	Interest		29,215,047	265	102,362		3,087,165	10,817	9
10	33	Real Estate Taxes		29,215,047	265	2,136		3,087,165	226	10
11	26	Insurance		29,215,047	265	169,087		3,087,165	17,867	11
12	27	Advertising & Promotions		29,215,047	265	(1,103)		3,087,165	(117)	12
13	25	Transportation		29,215,047	265	41,676		3,087,165	4,404	13
14	35	Car Rental		29,215,047	265	418		3,087,165	44	14
15	23	Conferences & Conventions		29,215,047	265	38,609		3,087,165	4,080	15
16	20	Subscriptions, Dues, Awards		29,215,047	265	14,089		3,087,165	1,489	16
17	21	Furniture & Fixtures		29,215,047	265	3,080		3,087,165	325	17
18	6	Machinery & Equipment		29,215,047	265	(6)		3,087,165	(1)	18
19	35	Equipment Rental		29,215,047	265	8,348		3,087,165	882	19
20	6	Equipment Repair & Maint		29,215,047	265	116,469		3,087,165	12,307	20
21	20	Employee Recruitment		29,215,047	265	(1,054)		3,087,165	(111)	21
22	7	Security & Waste Removal		29,215,047	265	12,399		3,087,165	1,310	22
23	21	All Other Miscellaneous		29,215,047	265	36,656		3,087,165	3,873	23
24	30	Depreciation		29,215,047	265	484,253		3,087,165	51,171	24
25	TOTALS					$ 5,685,659	$ 1,898,520		$ 600,803	25

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lutheran Social Services of Illinois
Street Address: 1001 E. Touhy Ave. Ste 50
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (847) 635-4600
Fax Number: (847) 635-6764

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	Salaries & Benefits	45,669,555	250	$ 764,920	$ 764,920	4,818,117	$ 80,699	1
2	22	Empl Benefits & Taxes		45,669,555	250	165,686		4,818,117	17,480	2
3	19	Prof Fees & Contract		45,669,555	250	159,317		4,818,117	16,808	3
4	21	Supplies, Telephone		45,669,555	250	45,527		4,818,117	4,803	4
5		Postage, Out. Printing		45,669,555	250			4,818,117		5
6	34	Rental of Space		45,669,555	250	2,789		4,818,117	294	6
7	5	Utilities		45,669,555	250			4,818,117		7
8	6	Bldg Repairs & Maintenance		45,669,555	250	16		4,818,117	2	8
9	32	Interest		45,669,555	250			4,818,117		9
10	33	Real Estate Taxes		45,669,555	250			4,818,117		10
11	26	Insurance		45,669,555	250	3,482		4,818,117	367	11
12	27	Advertising & Promotions		45,669,555	250			4,818,117		12
13	25	Transportation		45,669,555	250	9,361		4,818,117	988	13
14	35	Car Rental		45,669,555	250	488		4,818,117	51	14
15	23	Conferences & Conventions		45,669,555	250	6,764		4,818,117	714	15
16	20	Subscriptions, Dues, Awards		45,669,555	250	4,313		4,818,117	455	16
17	21	Furniture & Fixtures		45,669,555	250			4,818,117		17
18	6	Machinery & Equipment		45,669,555	250			4,818,117		18
19	35	Equipment Rental		45,669,555	250	9,350		4,818,117	986	19
20	6	Equipment Repair & Maint		45,669,555	250	1,647		4,818,117	174	20
21	20	Employee Recruitment		45,669,555	250	25,418		4,818,117	2,682	21
22	7	Security & Waste Removal		45,669,555	250			4,818,117		22
23	21	All Other Miscellaneous		45,669,555	250	4,840		4,818,117	511	23
24	30	Depreciation		45,669,555	250	6,910		4,818,117	729	24
25	TOTALS					$ 1,210,828	$ 764,920		$ 127,743	25

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lutheran Social Services of Illinois
Street Address: 1001 E. Touhy Ave. Ste 50
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (847) 635-4600
Fax Number: (847) 635-6764

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	Non Capital Direct Costs	5,427,946	2	$ 136,290	$ 136,290	3,087,165	$ 77,515	1
2	22	Empl Benefits & Taxes		5,427,946	2	59,458		3,087,165	33,817	2
3	19	Prof Fees & Contract		5,427,946	2	15,207		3,087,165	8,649	3
4	21	Supplies, Telephone		5,427,946	2	4,618		3,087,165	2,627	4
5		Postage, Out. Printing		5,427,946	2			3,087,165		5
6	34	Rental of Space		5,427,946	2	60		3,087,165	34	6
7	5	Utilities		5,427,946	2			3,087,165		7
8	6	Bldg Repairs & Maintenance		5,427,946	2			3,087,165		8
9	32	Interest		5,427,946	2			3,087,165		9
10	33	Real Estate Taxes		5,427,946	2			3,087,165		10
11	26	Insurance		5,427,946	2	616		3,087,165	350	11
12	27	Advertising & Promotions		5,427,946	2	291		3,087,165	166	12
13	25	Transportation		5,427,946	2	4,476		3,087,165	2,546	13
14	35	Car Rental		5,427,946	2			3,087,165		14
15	23	Conferences & Conventions		5,427,946	2	928		3,087,165	528	15
16	20	Subscriptions, Dues, Awards		5,427,946	2	250		3,087,165	142	16
17	21	Furniture & Fixtures		5,427,946	2			3,087,165		17
18	6	Machinery & Equipment		5,427,946	2			3,087,165		18
19	35	Equipment Rental		5,427,946	2	490		3,087,165	279	19
20	6	Equipment Repair & Maint		5,427,946	2	1,807		3,087,165	1,028	20
21	20	Employee Recruitment		5,427,946	2			3,087,165		21
22	7	Security & Waste Removal		5,427,946	2			3,087,165		22
23	21	All Other Miscellaneous		5,427,946	2	472		3,087,165	268	23
24	30	Depreciation		5,427,946	2	1,319		3,087,165	750	24
25	TOTALS					$ 226,282	$ 136,290		$ 128,699	25

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Tax Exempt Bonds		X	Refinance Mortage	N/A	9/23/93	$ 1,991,385	$ 3,144,206	8/15/20	0.0738	$ 231,651	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Mgmt Allocation per Sch VIII		X	Management Allocation	N/A	N/A	N/A	N/A	N/A	N/A	10,817	6
7												7
8												8
9	TOTAL Facility Related						$ 1,991,385	$ 3,144,206			$ 242,468	9
	B. Non-Facility Related*											
10	N/A			N/A	N/A	N/A	N/A	N/A	N/A	N/A		10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,991,385	$ 3,144,206			$ 242,468	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	$197,856.00	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	195,149	2
3. Under or (over) accrual (line 2 minus line 1).	$	(2,707)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	132,776	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	130,069	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	127,680	8
	2000	126,110	9
	2001	126,586	10
	2002	128,164	11
	2003	130,278	12

Line 2: Payment of $195,149 is based on 1st half of 2002 for $ 64,871
Line 2: 2nd half of 2002 for $64,871 and first half of 2003 for $ 65,407.
Line 4: Accrual of $132,776 is based on, 2nd half of 2003 for $65,407 and first half of 2004 for $ 67,369.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME P.A. Peterson Center for Health COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0021238

CONTACT PERSON REGARDING THIS REPORT Sonia Channa

TELEPHONE 847 390-1411 FAX #: 847 635-6764

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	163B-600 12-19-101-001	3 Stories, Steel Grids, Masonry	$ 130,814.20	$ 130,814.20
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ $130,814.20	$ $130,814.20

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 110,000 B. General Construction Type: Exterior Masonry Frame Steel Grids Number of Stories 3

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	192,020	1985	$ 8,455	1
2					2
3	TOTALS	192,020		$ 8,455	3

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	174		1942	1942	$ 95,858	$	50	$	$	$ 95,858	4
5			1979	1979	5,596,922	139,923	40	139,923		3,497,943	5
6											6
7											7
8											8
	Improvement Type**										
9	Boiler			1969	5,300		20			5,300	9
10	1975 Addition			1975	9,226		20			9,226	10
11	Remodeling			1977	10,074		16			10,074	11
12	Addition to Bldg			1980	2,874	72	40	72		1,762	12
13	Grab Bars			1982	6,151		10			6,151	13
14	Automatic Door Controls			1983	10,386		10			10,386	14
15	Remodel Suites to singles			1983	20,550		10			20,550	15
16	Convert Suites to Rooms			1984	11,900		10			11,900	16
17	Remodel Suites to singles			1986	15,800		10			15,800	17
18	Repair Damaged Roof			1993	4,296		10			4,296	18
19	Second Floor Redecoration			1994	89,701	4,795	10	4,795		89,701	19
20	Adjustment per IDPA 2nd Flr Decorating			1994	(2,730)		10	(137)	(137)	(2,730)	20
21	Landscaping			1980	69,073		10			69,073	21
22	Landscaping - Final 1980			1981	7,309		10			7,309	22
23	Sprinkler System			1984	3,654		10			3,654	23
24	Paving			1985	4,850		10			4,850	24
25	Deluxe Tub with Lift			1986	5,840		10			5,840	25
26	2nd Floor Shower Room			1988	13,898		10			13,898	26
27	Improvements			1988	4,414		10			4,414	27
28	Improvements			1989	15,688		10			15,688	28
29	ADJUSTMENT PER IDPA- 1989 IMPROVEMENTS			1989	20,266		10			20,266	29
30	ADJUSTMENT PER IDPA- 1989 IMPROVEMENTS			1989	35,052		10			35,052	30
31	New Roof			1990	41,995	1,680	25	1,680		24,349	31
32	Public Address System			1990	4,200		5			4,200	32
33	First Floor Remodeling			1990	62,210	2,488	25	2,488		33,620	33
34	ADJUSTMENT PER IDPA- 1990 1rst Flr Remodeling			1990	(3,590)		25	(144)	(144)	(2,082)	34
35	Parker Bath Tub			1991	9,390		7			9,390	35
36	Third Floor Remodeling			1992	99,312		10			99,312	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	ADJUSTMENT PER IDPA 1992 3rd Flr Remodeling	1992	$ (78,784)	$	10	$	$	$ (78,784)	37
38	ADJUSTMENT PER IDPA 1992 3rd Flr Remodeling	1991	54,938		10			54,938	38
39	Underground Fual Tank	1993	10,523		5			10,523	39
40	Security Cameras	1993	3,496		5			3,496	40
41	Bath Tub	1995	3,766	377	10	377		3,251	41
42	Parking lot	1995	16,425	657	25	657		5,590	42
43	IDPH Remodeling	1995	162,992	16,299	10	16,299		138,965	43
44	New Subacute Unit	1995	677,548	27,102	25	27,102		230,616	44
45	ADJUSTMENT PER IDPA 1995 Improvement to Equipment	1995	(63,067)		25	(2,523)	(2,523)	(23,968)	45
46	Adjustment per IDPA - 1995 Improv to CORF	1995	(30,219)		25	(1,208)	(1,208)	(11,479)	46
47	Parking Lot # 94-502	1995	416	42	10	42		354	47
48	Carpet/Vinyl Dining Room	1995	12,220	1,222	10	1,222		10,417	48
49	Glass & Glazing for Door	1997	775	78	10	78		559	49
50	New Doors & Smoke Closet	1997	1,910	191	10	191		1,334	50
51	Floor Covering in Kitchen	1998	2,047	205	10	205		1,294	51
52	Repair Roof-P.A.P.	1998	53,433	2,137	25	2,137		12,819	52
53	Zoning Permit Parking Lot	1998	898	90	10	90		530	53
54	Planting & Mulch for P.A.	1998	7,186	719	10	719		4,242	54
55	Parking Lot Expansion	1998	778	78	10	78		459	55
56	North Parking Lot Remodeling	1998	80,391	8,039	10	8,039		47,451	56
57	Consulting N. Parking Lot	1998	806	81	10	81		469	57
58	Repair Conduit Damage	1998	3,982	398	10	398		2,218	58
59	Carpeting for Apartment C	1999	17,200	1,720	10	1,720		12,908	59
60	Office Partition PAP	1999	4,862	486	10	486		1,620	60
61	Corridor Ventilation Upgrade	2000	63,500	2,540	25	2,540		10,357	61
62	Plumbing	2001	2,963	296	10	296		1,182	62
63	Install Cumberland Print	2001	3,160	126	25	126		505	63
64	Windows	2001	10,000	400	25	400		1,598	64
65	Porch- Railings-Floors	2001	7,648	306	25	306		1,222	65
66	Roofing	2001	11,475	1,148	10	1,148		4,577	66
67	Porch- Railings-Floors	2001	13,612	544	25	544		2,175	67
68	Fan Coil Unit	2001	5,635	564	10	564		2,248	68
69	Contract Flooring-Interior	2001	2,920	117	25	117		447	69
70	TOTAL (lines 4 thru 69)		$ 7,335,304	$ 214,920		$ 210,908	$ (4,012)	$ 4,579,183	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 7,335,304	$ 214,920		$ 210,908	$ (4,012)	$ 4,579,183	1
2	Wall coverings	2001	2,990	120	25	120		458	2
3	Furniture	2001	36,175	1,447	25	1,447		5,535	3
4	Carpet-Furnish and instal	2001	1,095	44	25	44		168	4
5	Room Equipment Furniture	2001	4,372	175	25	175		655	5
6	Room Equipment Furniture	2001	687	27	25	27		103	6
7	Room Equipment Furniture	2001	1,245	50	25	50		186	7
8	Room Equipment Furniture	2001	840	34	25	34		126	8
9	Room Equipment Furniture	2001	1,123	45	25	45		168	9
10	Room Equipment Furniture	2001	5,878	235	25	235		880	10
11	Room Equipment Furniture	2001	550	22	25	22		80	11
12	Room Equipment Furniture	2001	2,534	101	25	101		362	12
13	Carpet Wallpaper	2001	12,410	1,241	10	1,241		4,326	13
14	Furnish and Install Carpet	2001	840	84	10	84		286	14
15	Electric work 3rd Flr Kitchen	2001	3,348	134	25	134		456	15
16	Renovation of Assisted Living	2001	880	35	25	35		108	16
17	Renovation of Assisted Living	2001	4,363	436	10	436		1,340	17
18	Renovation of Assisted Living	2001	2,129	85	25	85		255	18
19	Soft Start for Elevator	2001	7,466	747	10	747		2,233	19
20	Architectual Services	2001	2,958	118	25	118		354	20
21	HVAC System Revisions	2001	9,000	900	10	900		2,691	21
22	Rewire rooms 206 & 208	2001	975	39	25	39		114	22
23	Architectual Services	2001	2,338	94	25	94		272	23
24	Landscaping	2001	8,954	895	10	895		3,328	24
25	Furnish and Install Carpet	2002	1,068	107	10	107		301	25
26	Deposit To Start Kitchen	2002	3,531	353	10	353		996	26
27	Floor Improvements	2002	1,150	115	10	115		305	27
28	Improvements	2002	19,528	1,953	10	1,953		5,182	28
29	Instalation of New Fire Place	2002	3,381	338	10	338		897	29
30	Architectual Services	2002	876	88	10	88		232	30
31	First Floor Construction	2002	35,000	3,500	10	3,500		8,703	31
32	Architectual Services	2002	1,962	196	10	196		488	32
33	Improvements	2002	2,500	100	25	100		249	33
34	TOTAL (lines 1 thru 33)		$ 7,517,450	$ 228,778		$ 224,766	$ (4,012)	$ 4,621,020	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 7,517,450	$ 228,778		$ 224,766	$ (4,012)	$ 4,621,020	1
2	Improvements	2002	1,870	187	10	187		449	2
3	Instalation of New Fire place	2002	1,187	119	10	119		285	3
4	Labor cost for removing	2002	6,690	669	10	669		1,555	4
5	Architectural Time	2002	443	44	10	44		99	5
6	Redecorate Ground Floor	2003	82,495	8,250	10	8,250		9,304	6
7	Duct work for air conditioning	2003	1,059	212	5	212		239	7
8	Redecorate Ground Floor	2003	5,535	553	10	553		577	8
9	Redecorate Ground Floor	2003	2,692	269	10	269		281	9
10	Redecorate Ground Floor	2003	2,700	270	10	270		282	10
11	Redecorate Ground Floor	2003	5,655	566	10	566		590	11
12	Redecorate Ground Floor	2003	1,584	158	10	158		165	12
13	Redecorate Ground Floor	2003	11,887	1,189	10	1,189		1,240	13
14	Redecorate Ground Floor	2003	1,098	110	10	110		115	14
15	Redecorate Ground Floor	2003	880	88	10	88		92	15
16	Redecorate Ground Floor	2003	468	47	10	47		49	16
17	Redecorate Ground Floor	2003	4,278	856	5	856		892	17
18	Redecorate Ground Floor	2003	17,076	3,415	5	3,415		3,561	18
19	Redecorate Ground Floor	2003	29,523	2,952	10	2,952		3,079	19
20									20
21	Emergency Plumbing	2004	5,048	21	10	21		21	21
22	Emergency Plumbing	2004	465	2	10	2		2	22
23	Emergency Outlets	2004	4,575	8	25	8		8	23
24									24
25									25
26									26
27	Management Assets- Security System	1999	1,047		10	839	839	N/A	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,705,705	$ 248,763		$ 245,590	$ (3,173)	$ 4,643,905	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,535,261	$ 120,303	$ 170,037	$ 49,734	Various	$ 552,808	71
72	Current Year Purchases	379,566	14,301	16,027	1,726	Various	16,027	72
73	Fully Depreciated Assets	609,531					609,531	73
74								74
75	TOTALS	$ 2,524,358	$ 134,604	$ 186,064	$ 51,460		$ 1,178,366	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Transp.	Handicapped Bus 1991	1991	$ 38,800	$	$	$	7	$ 38,800	76
77										77
78										78
79										79
80	TOTALS			$ 38,800	$	$	$		$ 38,800	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 10,277,318	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 383,367	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 431,654	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 48,287	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,861,071	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	95 Improvement CORF 1995	$ 30,219	$ 1,208	$ 12,687	86
87	Dodge Van 1997	17,032	1,541	17,032	87
88					88
89	Management Autos	2,297	351	N/A	89
90					90
91	TOTALS	$ 49,548	$ 3,100	$ 29,719	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 36,992 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)	N / A			
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts		N / A					9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	N / A		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$	$	48

***(See instructions.)**

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ N / A	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)		7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$	24 *

Note:
Lutheran Social Services of Illinois is unable to provide meaninful comparative balance sheets or statements of changes in equity for individual programs due to the commingling of cash, other asset and most liabilities in a complex, multi-funtional service agency.

Any Balance Sheet prepared with only those Assets with specific programs would not balance or present meaningful picture of that programs's Financial Statu

*** This must agree with page 17, line 47.**

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,530,709	1
2	Discounts and Allowances for all Levels	(179,971)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,350,738	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,435	13
14	Non-Patient Meals	7,347	14
15	Telephone, Television and Radio	23,822	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	1,540	20
21	Other Medical Services		21
22	Laundry	16,707	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 51,851	23
	D. Non-Operating Revenue		
24	Contributions	222	24
25	Interest and Other Investment Income***	5	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 227	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Vending Machine Income**	3	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,402,819	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,532,000	31
32	Health Care	4,594,647	32
33	General Administration	2,408,406	33
	B. Capital Expense		
34	Ownership	800,533	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	61,320	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,396,906	40
41	**Income before Income Taxes (line 30 minus line 40)****	(994,087)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (994,087)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N / A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,505	1,967	$ 66,651	$ 33.88	1
2	Assistant Director of Nursing	10,557	12,559	200,671	15.98	2
3	Registered Nurses	37,517	41,136	893,168	21.71	3
4	Licensed Practical Nurses	32,708	35,699	635,044	17.79	4
5	Nurse Aides & Orderlies	88,953	95,233	1,018,694	10.70	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	4,577	5,198	53,393	10.27	9
10	Activity Assistants					10
11	Social Service Workers	3,395	3,816	56,386	14.78	11
12	Dietician					12
13	Food Service Supervisor	7,946	9,249	103,642	11.21	13
14	Head Cook	7,719	8,221	77,919	9.48	14
15	Cook Helpers/Assistants	23,837	25,756	198,434	7.70	15
16	Dishwashers					16
17	Maintenance Workers	6,323	7,222	121,534	16.83	17
18	Housekeepers	15,720	17,246	131,338	7.62	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator	970	1,137	42,655	37.52	21
22	Other Administrative	1,637	1,917	35,563	18.55	22
23	Office Manager					23
24	Clerical	7,262	8,104	78,093	9.64	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	8,888	10,088	105,940	10.50	31
32	Other Health Care(specify)					32
33	Other(specify)	2,089	2,362	51,050	21.61	33
34	TOTAL (lines 1 - 33)	261,603	286,910	$ 3,870,175 *	$ 13.49	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	As Needed	$ 21,682	1,3	35
36	Medical Director	As Needed	6,503	9,3	36
37	Medical Records Consultant	As Needed	2,566	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	As Needed	510	10,3	39
40	Physical Therapy Consultant	As Needed	588,880	10a,3	40
41	Occupational Therapy Consultant	As Needed	367,865	10a,3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	As Needed	79,188	10a,3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)	As Needed	220,165	Various	46
47	Legal & Audit Accounting	As Needed	43,849	19,3	47
48					48
49	TOTAL (lines 35 - 48)		$ 1,331,208		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number P.A. Peterson Center for Health # 0021238 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Peggy J. Holt	Administrator	0	$ 42,655
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 42,655

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Duane, Morris & Heckscher	Legal Fees	$ 8,891
O'Keefe Lyons and Hyness LLC	Legal Fees	900
Frost Ruttenberg and Roth	Medicare Consultant/Report Ser	27,200
Office Team	Medicare Consultant/Report Ser	622
Duane, Morris & Heckscher	Medicare Consultant/Report Ser	1,556
Gary Anderson & Assoc. Inc.	Medicare Consultant/Report Ser	1,292
LSSI	Management Services	858,164
Revere Health Care	Acct/bookkeeping Temp	2,492
Accountemps	Acct/bookkeeping Temp	896
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 902,013

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 200,001
Unemployment Compensation Insurance	21,289
FICA Taxes	278,906
Employee Health Insurance	328,610
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	119,045
Management Allocation Benefits	89,148
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,036,999

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,879
Health Care Worker Background Check	
(Indicate # of checks performed)	
Advertising & Promation, Awards, Grants	24,592
Subscriptions and Books	
Membership Dues	602
Licenses & Fees	
Management Allocation	4,657
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 32,730

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Vehicle Operating Cost	12,998
Employee Milage Payments	5,634
Meals, Lodging	1,902
Seminar Expense	318
Conference & Conventions	1,248
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 22,100

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N / A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network $602**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **21,488** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **61,320**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **Yes** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **7,347**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/ A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Clifton Gunderson LLP** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **No** If no, please explain. **In Progress, will send as soon as availa**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.